

# XCEL HEALTHCARE PROVIDERS, INC.

1991 Lee Road  
Cleveland Heights, Ohio 44118  
Phone: (216) 426-9996 Fax: (216) 426-9922

## Items Required As Part of Our Application Process

- Completed Application
- Resume (if applicable)
- Valid ID (Driver License, State ID)
- Social Security Card
- HHA Certificate or STNA License
- Valid CPR & First Aid Training
- Physical & TB Test (must have been completed within the past year)
- Verifiable Employment References
- BCI check (requires a \$25 non-ref undable fee)

## How the Application Process Works

- Human Resources will review your completed application
  - All Items listed above must be turned in with your application before we will begin reviewing your credentials
- Employment verifications will be conducted
  - We ask that you have at least (2) verifiable previous employers
- If we believe you have the qualifications we are looking for, **we will call you** to schedule a day and time to complete the BCI fingerprinting
  - If your record is clear - orientation can begin shortly
  - If your record comes back as "mailed", employment **cannot** begin until we review your record
  - This process can take up to 4-6 weeks
- **WE ASK THAT YOU DO NOT CALL THE OFFICE TO CHECK THE STATUS OF YOUR APPLICATION. WE RECEIVE A HIGH VOLUME OF APPLICATIONS AND CANNOT TAKE THE TIME TO SPEAK TO EVERY APPLICANT REGARDING APPLICATION STATUS. WE WILL CALL YOU IF YOU ARE QUALIFIED**

## What You Should Know

- We prefer candidates with prior healthcare experience.
- Clean criminal background checks are a must.
- We are looking for open availability, Sunday through Saturday from 7am-10pm and Holidays.
- We believe in our Mission & Goals and expect all employees to follow the policies set by Xcel Healthcare Providers
- Our clients **are** our number one priority.

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## PRE-EMPLOYMENT SCREENING

To Be Considered for Employment by Xcel Healthcare Providers, You Must:

1. Have VERIFIABLE Home Health Care experience
  - With at least 75 hours of training in Home Health Care
  - OR
  - Have been State Tested and Certified
2. If you have a Criminal Record of any kind STOP! Do not complete this application. YOU MUST SPEAK WITH ONE OF THE AGENCY'S REPRESENTATIVES BEFORE PROCEEDING.
3. Have you ever been Convicted or Plead Guilty to an offense other than a minor traffic violation?                      Yes                      No

If yes, please explain:

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Please Note:

A conviction does not necessarily bar you from employment with Xcel Healthcare Providers.

4. Have you been a resident of Ohio for the past 5 years?                       Yes                       No

Ohio law requires applicants who come under final consideration for employment to be fingerprinted and undergo a satisfactory criminal background check.

I certify that I DO NOT have a Criminal Record of any kind or have written above an explanation for any charges that appear. Furthermore, I understand the consequences of falsified statements made on my application and/or this addendum.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

# APPLICATION FOR EMPLOYMENT

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, or any other legally protected status.

(PLEASE PRINT)

Position(s) Applied For	Date of Application
How Did You Learn About Us?	
<input type="checkbox"/> Advertisement	<input type="checkbox"/> Relative
<input type="checkbox"/> Employment Agency	<input type="checkbox"/> Friend
	<input type="checkbox"/> Inquiry
	<input type="checkbox"/> Other _____

Last Name	First Name	Middle Name
Address	Number	Street
	City	State
	Zip Code	
Telephone Number(s)	Social Security Number	

Best time to contact you at home is: ..... : ..... AM  
PM

If you are under 18 years of age, can you provide required proof of your eligibility to work? .....  Yes  No

Have you ever filed an application with us before? .....  Yes  No

If Yes, give date \_\_\_\_\_

Have you ever been employed with us before? .....  Yes  No

If Yes, give date \_\_\_\_\_

Do any of your friends or relatives, other than spouse, work here? .....  Yes  No

Are you currently employed? .....  Yes  No

May we contact your present employer? .....  Yes  No

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status  
*Proof of citizenship or immigration status will be required upon employment.* ....  Yes  No

Date available for work \_\_\_/\_\_\_/\_\_\_ What is your desired salary range? \_\_\_\_\_

Are you available to work:  Full-Time (please indicate 1 2 3 shift)

Part-Time (please indicate Mornings Afternoon Evenings)

Temporary (please indicate dates available \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_)

Are you currently on "lay-off" status and subject to recall? .....  Yes  No

Can you travel if a job requires it? .....  Yes  No

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

# EDUCATION

	Name and Address of School	Course of Study	Years Completed	Diploma Degree
Elementary School				
High School				
Undergraduate College				
Graduate Professional				
Other (Specify)				

Describe any specialized training, apprenticeship, skills and extra-curricular activities.

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Describe any job-related training received in the United States military.

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# EMPLOYMENT EXPERIENCE

Start with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude organizations which indicate race, color, religion, gender, national origin, disabilities or other protected status.

1.	Employer		Dates Employed		Work Performed
			From	To	
	Address				
	Telephone Number(s)		Hourly Rate/Salary		
			Starting	Final	
Job Title		Supervisor			
Reason for Leaving					
2.	Employer		Dates Employed		Work Performed
			From	To	
	Address				
	Telephone Number(s)		Hourly Rate/Salary		
			Starting	Final	
Job Title		Supervisor			
Reason for Leaving					
3.	Employer		Dates Employed		Work Performed
			From	To	
	Address				
	Telephone Number(s)		Hourly Rate/Salary		
			Starting	Final	
Job Title		Supervisor			
Reason for Leaving					
4.	Employer		Dates Employed		Work Performed
			From	To	
	Address				
	Telephone Number(s)		Hourly Rate/Salary		
			Starting	Final	
Job Title		Supervisor			
Reason for Leaving					

If you need additional space, please continue on a separate sheet of paper.

List professional, trade, business or civic activities and offices held.

*You may exclude membership which would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status:*


# ADDITIONAL INFORMATION

## Other Qualifications

Summarize special job-related skills and qualifications acquired from employment or other experience.

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## SPECIALIZED SKILLS (CHECK SKILLS/EQUIPMENT OPERATED)

<input type="checkbox"/> Terminal	<input type="checkbox"/> Spreadsheet	Production/Mobile Machinery (list)	Other (list)
<input type="checkbox"/> PC/MAC	<input type="checkbox"/> Word Processing	_____	_____
<input type="checkbox"/> Typewriter	<input type="checkbox"/> Shorthand	_____	_____
WPM ____	WPM ____	_____	_____
		_____	_____

*State any additional information you feel may be helpful to us in considering your application.*

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Note to Applicants: DO NOT ANSWER THIS QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS OF THE JOB FOR WHICH YOU ARE APPLYING.

Are you capable of performing in a reasonable manner, with or without a reasonable accommodation, the activities involved in the job or occupation for which you have applied? A review of the activities involved in such a job or occupation has been given.  YES  NO

## REFERENCES

1.	( )	
	(Name)	Phone #
	(Address)	
2.	( )	
	(Name)	Phone #
	(Address)	
3.	( )	
	(Name)	Phone #
	(Address)	

# APPLICANT'S STATEMENT

I certify that answers given herein are true and complete.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

## FOR PERSONNEL DEPARTMENT USE ONLY

Arrange Interview  Yes  No

Remarks \_\_\_\_\_

\_\_\_\_\_  
INTERVIEWER      DATE

Employed  Yes  No      Date of Employment \_\_\_\_\_

Job Title \_\_\_\_\_ Hourly Rate/  
Salary \_\_\_\_\_ Department \_\_\_\_\_

By \_\_\_\_\_

NAME AND TITLE

DATE

*This Application For Employment is sold for general use throughout the United States. Amsterdam Printing and Litho assumes no responsibility for the use of said form or any questions which, when asked by the employer of the job applicant, may violate State and/or Federal Law.*

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## Pre- Employment Reference Check

**Applicant Information - Employee to complete this section only**

Applicant Name: \_\_\_\_\_ Dale: \_\_\_\_\_  
*Last First M.I.*

Social Security Number: \_\_\_\_\_

*Applicant's Authorization: I hereby authorize the release of all information requested by Xcel Healthcare Providers. A photocopy or facsimile of this form, including this authorization, shall be valid and effective as the original.*

Signature: \_\_\_\_\_

**(APPLICANT DO NOT WRITE BELOW THIS LINE)**

Company: \_\_\_\_\_

Attn: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address Suite #*  
\_\_\_\_\_  
*City State ZIP Code*

### PREVIOUS EMPLOYER - PLEASE COMPLETE THE SECTION BELOW

Applicant was employed as:

Full Time  Part Time  PRN

Dates of Employment:

From: \_\_\_\_\_ To: \_\_\_\_\_

What was the applicant's reason for leaving? \_\_\_\_\_

Additional comments (Optional): \_\_\_\_\_

Name/title of person completing form: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Please fax completed form to (216) 426-9922

Thank you for your time and assistance



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*Last First M.*

Social Security Number: \_\_\_\_\_

*Applicants Authorization: I hereby authorize the release of all information requested by Xcel Healthcare Providers. A photocopy or facsimile of this form, including this authorization, shall be void and effective as the original.*

Signature: \_\_\_\_\_

**(APPLICANT DO NOT WRITE BELOW THIS LINE)**

Company: \_\_\_\_\_

Attn: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address Su/to #*

\_\_\_\_\_ *City State ZIP Cods*

### PREVIOUS EMPLOYER - PLEASE COMPLETE THE SECTION BELOW

Applicant was employed as:  Full Time  Part Time  PRN

Dates of Employment:

From: \_\_\_\_\_ To: \_\_\_\_\_

What was the applicant's reason for leaving? \_\_\_\_\_

Additional comments (Optional): \_\_\_\_\_

Name/Title of person completing form: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Please fax completed form to (216) 426-9922

Thank you for your time and assistance

**Xcel Healthcare Providers**  
**1991 Lee Road**  
**Cleveland Heights, Ohio 44118**

Waiver to Release Information

In accordance with the Privacy Act, the Right to Financial Privacy Act, the Freedom of Information Act, the Fair Credit Reporting Act and the Americans with Disabilities Act, all State and Local Requirements, I expressly authorize any person associated with any educational institution, past or present employer, any law enforcement agency: Federal/State or Local, any private/ public medical institution or vehicle records, education, medical history and overall mod of living to release this information to Xcel Healthcare Providers, Inc for the purpose of being considered for employment. I also authorize that a copy of this release be as valid as the original. **Furthermore, I authorize to be fingerprinted in accordance with S.B. 160 and am aware that I will be charged a fee of \$60.00 for BCI or \$75.00 for FBI. An initial deposit of \$25.00 will be paid up front with the balance deducted from my first paycheck.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Name (Please Print)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Drivers License Number

\_\_\_\_\_  
Address (Please Include City, State and Zip Code)

\_\_\_\_\_  
County

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## AVAILABILITY FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Message: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Do you have a car?  Yes  No

What date are you available for work? \_\_\_\_\_

What time are you available to work? From \_\_\_\_\_ am/pm -to- \_\_\_\_\_ am/pm

What days are you available to work? \_\_\_\_\_ Monday \_\_\_\_\_ Tuesday  
\_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday

Are you available to work weekends?  Yes  No

ALL NEW HIRES HAVE A 90-DAY PROBATIONARY PERIOD.  
IF YOU CALL OFF OR FAIL TO REPORT TO WORK WHILE ON PROBATION,  
YOU WILL BE TERMINATED.

**XCEL HEALTHCARE PROVIDERS, INC.**  
**CRIMINAL BACKGROUND NOTIFICATION STATEMENT**

The applicant \_\_\_\_\_ states that he/she has **not been** convicted of or plead guilty to any of the offenses listed below. For each offense for which the applicant has been convicted or plead guilty and has since had the conviction sealed, applicant must provide the Human Resource Director with full details of the conviction.

**HOMICIDE**

- RC 2903.01 Aggravated Murder
- RC 2903.02 Murder
- RC 2903.03 Voluntary Manslaughter
- RC 2903.04 Involuntary Manslaughter

**ASSAULT**

- RC 2903.11 Felonious Assault
- RC 2903.12 Aggravated Assault
- RC 2903.13 Assault
- RC 2903.16 Failing to provide for functionally impaired person

**PATIENT ABUSE AND NEGLECT**

- RC 2903.34 Patient Abuse, Neglect
- RC 2903.341 Patient Endangerment

**KIDNAPPING AND RELATED OFFENSES**

- RC 2905.01 Kidnapping
- RC 2905.02 Abduction
- RC 2905.04 Child Stealing
- RC 2905.05 Criminal Child Enticement

**SEX OFFENSES**

- RC 2907.02 Rape
- RC 2907.03 Sexual Battery
- RC 2907.04 Unlawful sexual conduct with a minor, formerly  
Corruption of a minor
- RC 2907.05 Gross sexual imposition
- RC 2907.06 Sexual imposition
- RC 2907.07 Importuning
- RC 2907.08 Voyeurism
- RC 2907.09 Public Indecency
- RC 2907.12 Felonious Sexual Penetration
- RC 2907.21 Compelling Prostitution
- RC 2907.22 Promoting Prostitution
- RC 2907.23 Procuring
- RC 2907.25 Prostitution
- RC 2907.31 Disseminating matter harmful to juveniles
- RC 2907.32 Pandering Obscenity
- RC 2907.321 Pandering Obscenity involving a minor
- RC 2907.322 Pandering Sexually oriented matter involving a minor
- RC 2907.323 Illegal Use of minor in nudity-oriented material or  
performance

**ROBBERY & BURGLARY**

- RC 2911.01 Aggravated Robbery
- RC 2911.02 Robbery
- RC 2911.11 Aggravated Burglary
- RC 2911.12 Burglary

**OFFENSES AGAINST FAMILY**

- RC 2919.12 Unlawful Abortion
- RC 2919.22 Endangering Children
- RC 2919.24 Contributing to the unruliness or delinquency of child
- RC 2919.25 Domestic Violence

**WEAPONS CONTROL**

- RC 2923.12 Carrying concealed weapon
- RC 2923.13 Having weapons while under disability
- RC 2923.161 Improperly discharging a firearm at or into a  
habitation or school

**DRUG OFFENSES**

- RC 2925.02 Corrupting another with drugs
- RC 2925.03 Trafficking in drugs
- RC 2925.04 Illegal Manufacture of Drugs or Cultivation of Marijuana
- RC 2925.05 Funding of Drugs or Marijuana Trafficking
- RC 2925.06 Illegal Administration or Distribution of Anabolic Steroids
- RC 2925.11 Possession of Drugs (as long as it is not a minor possession  
offense)

**OTHERS**

- RC 3716.11 Placing harmful objects in food or confection
- A violation of RC 2919.23 that would have formerly violated RC 2905.04

**ADDITIONAL DISQUALIFYING OFFENSES**

A felony contained in the Revised Code that is not listed above if the felony bears a direct and substantial relationship to the duties and responsibilities of the position being filled.

Any offense contained in the Ohio revised Code constituting a misdemeanor of the first degree on the first offense and a felony on the subsequent offense, if the offense bears a direct and substantial relationship to the position being filled and the services being provided.

A violation of an existing or former municipal ordinance or law of this State, any other state, or the United States, if the offense is substantially equivalent to any of the offenses listed above.

The applicant agrees to inform the Human Resources Department in writing if, while employed by Xcel Healthcare Providers, Inc., the applicant is ever formally charged with, convicted of or pleads guilty to any of the offenses listed above. Such notification must be within 14 calendar days of the charge, conviction, or guilty pleas. The applicant understands that failure to notify the Human Resource Director may result in the applicant being dismissed from employment.

The applicant states that the above information is complete, true and accurate under the penalty of perjury. The applicant understands that this information is a condition of employment and that the agency is relying on the accuracy of the information in making any offer of employment to the applicant. The applicant understands that he/she may be discharged if any of the above information is false, incomplete or misleading.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date